Healthcare Providers

The information below is a list of important fields on the new CMS-1500 claim form for providers that bill using a NPI # . All fields that are not listed are not needed to process a claim for Montana Medicaid.

Client Has Medicaid Coverage Only

CMS-1500

Field #	Field Title	Instructions
Client Information		
2*	Client's Name	Enter patient's name as seen on client's Montana's Healthcare Programs information
10d, *	Client's ID	Enter the client's ID number as it appears on the client's Montana's Healthcare Programs information.
1a, 9a, 11**	Client's ID	If Client's ID is not located in 10d these three fields are searched for the number
Provider Information		
17a **	Referring Provider's Passport #	Enter Referring Provider's Passport number if a Passport client (a qualifier is not necessary).
17b **	Referring Provider's NPI #	Enter Referring Provider's NPI #
24a shaded area	NDC	Enter the qualifier, N4, followed by the NDC (NDC should not have punctuation, dashes or spaces), units qualifier and units as described by the qualifier
24i shaded**	ID Qualifier	**ZZ** for the Taxonomy qualifier
24j shaded**	Taxonomy Code	Enter the Taxonomy code for the rendering provider
24j **	NPI Number, Rendering Prov	Enter NPI Number for the rendering provider.
31*	Signature and Date	Enter Signature and Date
33*	Billing Provider Info	Enter Physical Address with a 9 digit ZIP code and phone number
33a*	NPI #	Enter NPI number for billing/pay-to provider.
33b*	Taxonomy #	Enter the qualifier (ZZ) and the billing provider's taxonomy code
Billing Information		
21.1 – 21.4*	Diagnosis codes	Enter at least one diagnosis
24a*	Date(s) of Service	Enter the dates of service include beginning and ending date even if same
24b*	Place of Service	Enter the code for place of service
24c**	EMG	Emergency Indicator if applicable
24d*	Procedure Code	Enter the procedure code used/ Enter Modifiers if applicable
24e*	Diagnosis Pointer	Enter the corresponding diagnosis pointer (1,2,3,or4) that refers to the codes in field 21
24f*	Charges	Enter the total charge for this line
24g*	Days/Units	Enter the days or units used for the procedure
28*	Total Charges	Enter total charges from all line items.

* = Required Field
** = Conditional (Required if applicable)

Rendering required if pay-to (billing) is one of the following:

- Podiatry Clinic
- Physical Therapist Clinic
- Speech Therapist Clinic
- Occupational Therapist Clinic
- Dental Clinic
- Physician Clinic
- Dedicated Emergency Department
- General Group or Clinic
- Provider Based Clinics
- Hospitals
- IDTF

Medicaid Only Coverage — Healthcare Providers

Fill Colors (shaded areas are slightly darker):
- Required Fields
- Conditional Fields
- Other

Border Colors
- Client Fields
- Provider Fields
- Billing Fields

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID [X] (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Flintstone, Fred T

3. PATIENT'S BIRTH DATE: 08 30 60 | SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 112 Rocky Rd.

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Bedrock | STATE: BC

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

CITY | STATE

ZIP CODE: 54321-1234 | TELEPHONE (Include Area Code): (406) 765-4321

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Medicaid

d. INSURANCE PLAN NAME OR PROGRAM NAME

0d. RESERVED FOR LOCAL USE: 123456789

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY: 01 01 07 | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Great Gazoo MD

17a. 9954321

17b. NPI 1234567890

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 285.21

2.

3.

4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	N4 55513009701 ML1									ZZ	36LP00000X
1	01 01 07	01 01 07	11		J0881	1	1500 00	500	Y	NPI	1213456789
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 99-9999999 | SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 123456789

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 1500 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 1500 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Rocky Shalestone, MD | 01/01/07

SIGNED | DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI | b.

33. BILLING PROVIDER INFO & PH #: (406) 555-1234

Yabba-Dabba Center
2121 Granite Slab Dr.
Bedrock, BC 54321-1234

a. 9876543210 | b. ZZ 400RT0010X

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Atypical Providers

The information below is a list of important fields on the new CMS-1500 claim form for providers that bill using a NPI # . All fields that are not listed are not needed to process a claim for Montana Medicaid.

Client Has Medicaid Coverage Only

CMS-1500		
Field #	**Field Title**	**Instructions**
Client Information		
2*	Client's Name	Enter patient's name as seen on client's Montana's Healthcare Programs information
10d, *	Client's ID	Enter the client's ID number as it appears on the client's Montana's Healthcare Programs information.
1a, 9a, 11**	Client's ID	If Client's ID is not located in 10d these three fields are searched for the number
Provider Information		
31*	Signature and Date	Enter Signature and Date
33*	Billing Provider Info	Enter Physical Address with a 9 digit ZIP code and phone number
33a**	NPI #	Enter NPI number for billing provider. If billing with a proprietary ID, leave 33a blank.
33b**	Taxonomy # Proprietary ID	Enter the qualifier (ZZ) and the billing provider's taxonomy code. Enter the 1D qualifier and the billing provider's Montana's Healthcare Programs number.
Billing Information		
21.1 – 21.4*	Diagnosis codes	Enter at least one diagnosis
24a*	Date(s) of Service	Enter the dates of service include beginning and ending date even if same
24b*	Place of Service	Enter the code for place of service
24c**	EMG	Emergency Indicator if applicable
24d*	Procedure Code	Enter the procedure code used/ Enter Modifiers if applicable
24e*	Diagnosis Pointer	Enter the corresponding diagnosis pointer (1,2,3,or4) that refers to the codes in field 21
24f*	Charges	Enter the total charge for this line
24g*	Days/Units	Enter the days or units used for the procedure
28*	Total Charges	Enter total charges from all line items.

* = Required Field
** = Conditional (Required if applicable)

Atypical providers may use either NPI/taxonomy if used to enroll or the new Montana's Healthcare Programs provider number.

Medicaid Only Coverage — Ayptical

Fill Colors (shaded areas are slightly darker):
- Required Fields
- Conditional Fields
- Other

Border Colors
- Client Fields
- Provider Fields
- Billing Fields

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Flintstone, Fred T

3. PATIENT'S BIRTH DATE: 08 30 60 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 112 Rocky Rd.

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Bedrock STATE: BC

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

CITY STATE

ZIP CODE: 54321-1234 TELEPHONE (Include Area Code): (406) 765-4321

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Medicaid

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 123456789

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY 01 01 07 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Great Gazoo MD

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 250.00

2.

3.

4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	01	01	07	01	01	07	13		T2031		1	60.00	1	Y	NPI
2															NPI
3															NPI
4															NPI
5															NPI
6															NPI

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 99-9999999

26. PATIENT'S ACCOUNT NO.: 123456789

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 60.00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 60.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Rocky Shalestone, MD SIGNED 01/01/07 DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH #: (406) 555-1234

Yabba-Dabba Center
2121 Granite Slab Dr.
Bedrock, BC 54321-1234

a. NPI b. 1D 9954321

NUCC Instruction Manual available at: www.nucc.org

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